| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 155336 | A. BUILDING 00<br>B. WING | 07/08/2011 |

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| DECATUR TOWNSHIP CARE AND REHABILITATION CENTER | 4851 TINCHER ROAD<br>INDIANAPOLIS, IN46221 |

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| F0000 | This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00092083.<br><br>Complaint IN00092083 - Substantiated. Federal/state deficiencies related to the allegations are cited at F203.<br><br>Survey dates: July 5, 6, 7 & 8, 2011<br><br>Facility number: 000229<br>Provider number: 155336<br>AIM number: 100266850<br><br>Survey team:<br>Marcy Smith RN TC<br>Leia Alley RN<br>Patti Allen BSW<br>Karina Gates, Medical Surveyor<br>Barbara Hughes RN<br><br>Census bed type:<br>SNF/NF: 78<br>Total: 78<br><br>Census payor type:<br>Medicare: 12<br>Medicaid: 48<br>Other: 18<br>Total: 78 | F0000 | The Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Decatur Care & Rehabilitation Center does not admit that the deficiency listed on this form exist, nor does the Center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. The Center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency. | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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| | Sample: 16<br><br>These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2.<br><br>Quality review 7/15/11 by Suzanne Williams, RN | | | |

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| F0203 SS=D | Before a facility transfers or discharges a resident, the facility must notify the resident and, if known, a family member or legal representative of the resident of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand; record the reasons in the resident's clinical record; and include in the notice the items described in paragraph (a)(6) of this section.<br><br>Except when specified in paragraph (a)(5)(ii) of this section, the notice of transfer or discharge required under paragraph (a)(4) of this section must be made by the facility at least 30 days before the resident is transferred or discharged.<br><br>Notice may be made as soon as practicable before transfer or discharge when the health of individuals in the facility would be endangered under (a)(2)(iv) of this section; the resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (a)(2)(i) of this section; an immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (a)(2)(ii) of this section; or a resident has not resided in the facility for 30 days.<br><br>The written notice specified in paragraph (a)(4) of this section must include the reason for transfer or discharge; the effective date of transfer or discharge; the location to which the resident is transferred or discharged; a statement that the resident has the right to appeal the action to the State; the name, address and telephone number of the State long term care ombudsman; for nursing facility residents with developmental disabilities, the mailing address and telephone | | | |

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| | number of the agency responsible for the protection and advocacy of developmentally disabled individuals established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act; and for nursing facility residents who are mentally ill, the mailing address and telephone number of the agency responsible for the protection and advocacy of mentally ill individuals established under the Protection and Advocacy for Mentally Ill Individuals Act. | | | |
| | Based on record review and interview, the facility failed to ensure a transfer/discharge notice was given to 2 of 3 residents reviewed for receiving discharge notices after being sent to the hospital, in a sample of 16. (Resident #A and #B)<br><br>Findings include:<br><br>1. The closed record of Resident #A was reviewed on 7/7/11 at 8:45 a.m.<br><br>The resident was admitted to the facility on 5/26/11 with diagnoses which included, but were not limited to, difficulty walking, alcohol induced persisting amnesic disorder, Korsakoff dementia and liver failure. He was transferred to a local hospital on 6/1/11 where he was admitted with diagnoses of septic shock secondary to pneumonia and respiratory failure. A Minimum Data Set assessment dated 6/1/11 indicated "Discharge assessment-return | F0203 | a. Due to the resident's (A) choice to choose another facility, this facility was unable to correct any deficiency for this resident. The facility had every intention to readmit resident (A) back into the facility when able to meet the needs of the resident. b. The licensed nurses will be reeducated by the Social Service Director/Designee by 7/29/11 to provide a copy of the transfer/discharge to those residents when the resident's condition changes and the facility is unable to meet the needs upon discharge to the hospital or if a change in condition while in patient at a hospital makes the facility unable to meet the needs of the resident. c. Every resident sent out to the hospital or other placement will have his or her chart be reviewed in clinical meeting and if their needs have changed to the point that the facility can no longer meet the needs a Transfer/Discharge form will be delivered to the current placement by a staff member from our facility to ensure the | 07/29/2011 |

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| | anticipated."<br><br>A nurse's note, dated 6/10/11, indicated the local hospital called requesting readmission to the facility for Resident #A. The nurse's note indicated a reassessment of the resident would be done.<br><br>A nurse's note from 6/14/11 indicated the assessment was completed. The resident was found to be in "full body restraints & currently in a full body restraint bed - denial readmission R/T unable to meet resident's needs @ this time will reassess [after] restraints off & able to meet safety needs."<br><br>A nurse's note dated 6/16/11 indicated "Reassessed restraint...restraints removed 6/15/11. Resident was on Zyprexa 10 mg [milligrams] [twice a day], Klonopin 3 mg, Seroquel [antipsychotic/behavior medications] & PRN [as needed] Morphine. Resident was unable to be assessed r/t [related to] not responding to nurse."<br><br>A nurse's note dated 6/17/11 indicated "Attempted to assess Resident x3 [times]. Asked disch[arge] planner to have floor nurse contact writer to assure resident was awake prior to nurse going to hosp[ital] - Nurse called & assured resident was | | resident has all the information needed for an appeal. d. When a resident is transferred or discharged from the center, the Social Services Director/Designee will review the documentation at the clinical morning meeting to assure the notice was sent with the resident or POA to be delivered to the place of current residency to allow the resident the right to appeal the decision. The Notice of Transfer or Discharge will be provided to the resident or POA via certified mail or hand delivered. The Social Services Director will complete the audit 3 times a week X4 weeks, then monthly X5 to assure compliance. The Social Services Director/Designee will review the audits in the monthly Performance Improvement meeting for any further recommendations. | |

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| | awake. Nurse...to hosp[ital] & noted resident had 1 on 1 sitters @ all times, called hosp[ital] and was unable to meet needs @ this time for safety."<br><br>During an interview with the Administrator and Director of Nursing Services (DNS) on 7/7/11 at 2:00 p.m. they indicated they did not give a transfer/discharge notice to the resident or the resident's responsible party with information regarding the reason for the transfer/discharge and his rights as a resident at any time during his hospitalization. They indicated they did not do so because when they sent him to the hospital they expected him to return to the facility.<br><br>2. The record of Resident #B was reviewed on 7/8/11 at 10:30 a.m. The resident was admitted to the facility on 5/2/11 from a local hospital with diagnoses which included, but were not limited to, alcohol dependence, persistent mental disorder, depression and suicidal ideation. He was discharged from the facility back to the local hospital on 5/3/11.<br><br>A nurse's note, dated 5/3/11 at 7:00 a.m. indicated Resident #B was sent to the emergency department of the local hospital because the facility was not able | | | |

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| | to meet his needs secondary to his "constant exit seeking."<br><br>During an interview with the DNS on 7/8/11 at 10:50 a.m., she indicated a transfer/discharge notification was not given to the resident or his responsible party at any time because the facility has a contract with the local hospital, and they can send residents back to the local hospital without transfer/discharge paperwork when they are not able to care properly for them.<br><br>During an interview with the Administrator on 7/8/11 at 1:30 p.m., he indicated he was not able to find the part of the contract with the local hospital that says they are not required to give a transfer/discharge form to residents being sent from the facility to the local hospital secondary to the facility's not being able to care for the resident properly. He indicated he had called their representative from the local hospital but she had not returned his call.<br><br>This federal tag relates to Complaint IN00092083.<br><br>3.1-12(a)(6)(A) | | | |

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| F0257 SS=E | The facility must provide comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 - 81° F<br>Based on observation and interview, the facility failed to provide safe comfortable temperature less than 81 degrees Fahrenheit, in the East Dining Room and East Corridor on 7-6-11. This affected 6 of 6 residents who attended the group meeting (#C, #D, #E, #F, #G, #H) and had the potential to affect 58 residents in the facility, who attend the group activities held in the East Dining Room, 20 residents who eat their meals in the East Dining Room, and 49 resident who use the East Corridor, of a total of 78 residents.<br><br>Finding include:<br><br>1. On 7/5/11 at 11:15 a.m. the Activity Director was asked to assist in setting up a time for a Group meeting for surveyors with residents who would be able to provide the surveyors with accurate information about the facility. During the Group Meeting on 7-6-11 at 1:00 p.m., with the residents, 6 of 6 residents (Residents #C, #D, #E, #F, #G and #H) indicated the air conditioning had been broken for a month, and the East Dining Room and East Hallway were too warm. | F0257 | a. The residents eating or attending activities in the East dining room and/or using the east hallway has the potential to be affected. The East dining room area was closed off for the evening meal and residents were seated in the activity room, where the air temperature was in the comfortable range of 71-81 degree F for the evening meal, extra hydration was passed out to all the residents who were able to have fluids and or accepted the extra hydration. Two air conditioners were purchased immediately and placed in the east dining room area and temperatures were monitored hourly. The double doors on the end of the East hall leading outside were closed to assist with keeping the temperature in the hall and East dining room continue falling into the proper range. The residents on both hallways have independent air conditioners in each room for his or her preference. No adverse effects were noted. b. The residents were asked to be re-routed to the activity room during the evening meal on 7/6/11 related to the temperature being above the comfort set forth by the state regulations without any opposition. No adverse effect noted for any resident in the | 07/29/2011 |

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| | 2. On 7-6-11 at 2:20 p.m., the temperature in the East Corridor was 83 degrees Fahrenheit, and the East Dining Room was 85 degrees Fahrenheit, where 11 residents were playing Jackpot Bingo.<br><br>3. On 7-6-11 at 3:00 p.m., during observation with the Director of Nursing (D.O.N.), the temperature in the East Corridor was 84 degrees Fahrenheit and the East Dining Room was 86 degrees Fahrenheit. The D.O.N. indicated the high temperatures had the potential to affect the residents who eat in the East Dining Room.<br><br>4. On 7-6-11 at 3:35 p.m., in a interview with the Maintenance Director and Administrator, the Maintenance director indicated they had been having trouble with the air conditioning for the kitchen, East Dining Room and East Corridor for about 2 weeks. He indicated that the temperatures of the East Corridor and East Dining Room had not been monitored.<br><br>5. During an interview with the Corporate Regional Consultant on 7-6-11 at 5:45 p.m., she indicated the residents would not be eating in the East Dining Room because of the high temperature.<br><br>6. In an interview on 7-8-11 at 11:00 | | facility. c. The facility has replaced the equipment related to the air temperatures on 7/6/11. d. The air conditioning equipment is inspected monthly by Maintenance Director. The Maintenance Director/Designee prior to the summer season will perform an annual air conditioning checkup of systems to assure comfortable temperature range. The Maintenance Director/Designee will monitor the air temperatures throughout the facility every hour for a 24 hour period then q shift for one week, followed by weekly X4, then monthly X3. | |

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| | a.m., the D.O.N. indicated the high temperatures had the potential to affect the 49 residents residing on the East Wing, the 20 residents who eat in the East Dining Room, and the residents who attend activities in held in the East Dining Room.<br><br>7. In an interview on 7-8-11 at 1:30 p.m., the Activity Director indicated the high temperatures in the East Dining Room had the potential to effect the 58 residents who attend activities held in the East Dining Room.<br><br>3.1-19(h) | | | |
| F0371 SS=F | The facility must -<br>(1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and<br>(2) Store, prepare, distribute and serve food under sanitary conditions<br>Based on observation and interview, the facility failed to ensure dishes and equipment used to store and prepare food were clean or maintained in a sanitary condition during 2 of 3 kitchen observations. This had the potential to affect 66 of residents who received meals from the kitchen in the facility population of 78.<br><br>Findings include: | F0371 | a. The food items not dated and labeled have the potential to affect all resident who eat in the facility. b. An immediate audit for date and label of all the food products was completed on 7/5/11. No other resident was affected due to the unlabeled and undated food was discarded. c. The Nutritional Service Director/Designee will reeducate all dietary staff concerning the proper procedure of labeling and dating all food products as per | 07/29/2011 |

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| | During the dietary walk through on 7/5/11 at 10:30 a.m., with the Dietary Manager, the following was observed:<br><br>1. The hood located above the stove, steamer, and the steam-hold, had rust and bubbled, flaked and peeling paint.<br><br>The Dietary Manager indicated at this time the equipment was used to prepare residents' food and the loose paint could fall into the residents' food.<br><br>2. The wall where the covers for resident trays were stored was damaged with chipped and peeling paint.<br><br>The Dietary Manager indicated at this time the covers were used to cover residents' food trays and the loose paint could fall into the lids and be placed over residents' food.<br><br>3. There were two ceiling lights above where resident drinks were made and clean dishes stored, uncovered.<br><br>The Dietary Manager indicated at this time the light bulbs were uncovered, and if they broke the glass would fall in to the stored clean dishes and the area where resident drinks were prepared. | | policy and guidelines by 7/29/11. d. The NSD/Designee will do four audits per week at random to include all three meal services, then weekly for a month then monthly for 4 months and document on an audit form presenting to the PI process for any findings and educate any staff not following the guidelines set up by the standards per policy and state regulations. a. The touching of the food with a gloved hand after touching other utensil was corrected immediately by replacement of the meal so no resident was affected by this deficiency. b. The residents eating meals from the dietary department have the potential to be affected by improper handling of the food. c. The dietary staff handling food will be reeducated by NSD/Designee by 7/29/11 on the proper way to touch, turn and cut sandwiches or other items needing handling prior to serving the residents. The NSD/Designee will audit different meal times to ensure line staff is properly handling food items as per guidelines and education will continue as needed to provide proper handling of food items. d. The NSD/Designee will monitor the handling of food products randomly on the line 3 times a week X4 weeks, then weekly X4 weeks, then monthly for 3 months using an audit tool to present to the PI process. a. The hood above the stove, steamer, and | |

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| | During the noon meal service on 7-5-11 at 11:45 a.m., there were 11 blue, four-sided trays located in front of the steamer. Six of the blue trays contained bowls used to serve resident food. The trays were covered in a dried white, flaky substance, that was falling off onto the stored clean bowls. Cook # 1 was observed using the bowls during noon meal service.<br><br>The Dietary Manager indicated they started noticing the white substance when they got the new dish washing machine about a month ago. She thought the dish machine pulverized the food particles and it stayed on the trays. She indicated that she was going to start storing the bowls on flat trays, and not use the four-sided blue trays. | | the steam-hold with flaked and peeling paint, the walls damaged by chipped and peeling paint where the covers for the residents trays were stored, and the two lights above the area where residents drinks were made and dishes stored has the potential to affect all residents who have meals prepared by dietary by peeling paint or glasses falling into the food. No adverse effects were noted. b. The hood has been sanded and repainted on 7/8/11, the wall was covered with a non-peeling type board on 7/5/11 and the lights were covered on 7/5/11. All repairs were completed prior to exiting of the annual survey. c. Nutrition Services Director/Designee will check environmental areas in the kitchen daily and report any repairs to the Administrator/Maintenance Director immediately. d. NSD/designee to do environmental walk through weekly X4, then monthly X5 with Administrator/Designee and report to the Performance Improvement committee any concerns. a. Blue dishwashing trays containing bowls with white debris flaking and falling off sides have the potential to affect all residents who has food prepared in the dietary services. No adverse effects were noted. b. All blue racks are being replaced. Bowls are off loaded to netted trays. Dishes are sprayed to | |

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| | 4. On a tour of the kitchen at 10:30 A.M. on July 5, 2011, the following observations were made:<br><br>a) A package of opened lettuce and a tray of wrapped cheese sandwiches were observed on the shelf of the refrigerator without dates. | | decrease the amount of food going into the dish machine, and traps are to be cleaned before and after use and as needed. c. All blue trays are being replaced by 7/29/11. d. NSD/designee to do 4 audits a week for any debris or residue on any dishes used in the dish machine until blue racks are replaced. a. Cups with residue inside have the potential to affect all residents who use cups from dietary service. b. The cups were cleaned and bleached on 7/8/11 by Nutrition Services Director to remove residue from the inside. No adverse effects noted. c. Bleaching cups has been added to the cleaning schedule. The NSD/Designee to do a random audit of cups weekly to prevent residue buildup in the drinking utensils. d. Weekly audits on checking residue on cups, bowls, and glasses will be randomly checked weekly X4 at different meal services, then monthly X5. Report audits to the PI process monthly with findings. | |

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| | 155336 | A. BUILDING 00<br>B. WING | 07/08/2011 |

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| | b) The ceiling above the stove and a steam table was noted to be cracked with flaking paint.<br><br>c) There were 6 blue dishwashing trays observed, containing bowls being used by Cook #1 for lunch, that had white debris flaking and falling off the sides.<br><br>During an interview with the Dietitian on July 5, 2011 at 12:25 P.M., who also observed the trays with flaking debris, she indicated that the dishwasher was probably pulverizing the food and it was sticking to the trays.<br><br>5. At 10:45 A.M. on July 5, 2011, Cook #1 was observed touching the handle of a stainless steel serving cart with her gloved hands, to move it closer, and then putting bread slices from a pan onto residents' dishes without changing gloves. She was also observed placing her same gloved hand on top of salad she put in a resident's bowl, to keep it from falling out after touching the cart.<br><br>At 5:00 P.M. on July 6, 2011, Cook #1 was observed serving food into dishes from the steam table, at which time she moved a plastic serving cart to and from the steam table to remove cheese sandwiches and place them on a portable grill located on top for grilling. She then | | | |

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| | removed the grilled cheese from the grill and touched it with her gloved hand to assist with cutting it into and placed the sandwiches on the residents' trays.<br><br>6. On July 7, 2011 at 12:30 P.M., an observation of coffee cups was made with the Dietary Manager, of cups in the trays being used in the kitchen for lunch. She was observed wiping out 11 cups with her hand and removing a dark brown residue from the inside of 6 of them.<br><br>3.1-21(i)(3) | | | |

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| F0441 SS=D | The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.<br><br>(a) Infection Control Program<br>The facility must establish an Infection Control Program under which it -<br>(1) Investigates, controls, and prevents infections in the facility;<br>(2) Decides what procedures, such as isolation, should be applied to an individual resident; and<br>(3) Maintains a record of incidents and corrective actions related to infections.<br><br>(b) Preventing Spread of Infection<br>(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.<br>(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.<br>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.<br><br>(c) Linens<br>Personnel must handle, store, process and transport linens so as to prevent the spread of infection. | | | |
| | Based on observation, interview and record review, the facility failed to ensure proper infection control techniques were used by the laundry department. This affected 3 of 62 residents who have | F0441 | a. The residents affected by the deficiency of having clothing dragged on the floor and or stepped on were immediately corrected by rewashing of the clothing for residents 76, 20 and | 07/29/2011 |

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| | laundry services provided by the facility. Residents affected were Residents #76, #61 and #20.<br><br>Findings include:<br><br>During an observation on 7/6/11 at 3:35 p.m., Employee #4 was observed taking clean clothing off a large rack and putting it away into residents rooms. Employee #4 was observed taking a night gown, belonging to Resident #76, off the rack. Employee #4 let the bottom part of the gown sweep the floor of the hallway and then placed it in residents' room. Employee #4 also handled a dress belonging to Resident #20 in the exact same manner.<br><br>Employee #4 was then observed outside the room of Resident #61. Employee #4 was observed taking a dress for Resident #61 off of the rack, sweeping it across the floor, and accidentally stepped on the dress and took the dress and placed it in Resident #61's room.<br><br>A facility policy dated 2/2/03, untitled, did not indicate any information was available in regards to clothing and infection control measures.<br><br>During an interview on 7/7/11 at 9:30 a.m. the facility Administrator indicated | | 61. The housekeeper removed the affected clothing on 7/6/11. No adverse effects were noted. b. The residents who have clothing washed and delivered at the facility have the potential to be affected by improper handling of his or clothing maintaining the proper infection control standards. No other incidents were noted. c. The laundry housekeeping staff have been reeducated on the proper handling of clothing to prevent an infection control issue. Laundry and housekeeping employees have been reeducated on the proper procedure of passing personal laundry of all residents by 7/29/11 by ADNS/Designee. d. Laundry aides will be audited weekly X8 for proper handling of personal items when passing on the halls by the supervisor of laundry/housekeeping then monthly for three months. The ADNS/Designee will monitor for compliance for 4 months on observation of passing personal items on the halls to maintain acceptable infection control guidelines and presenting any findings to the infection control committee. These audits will be reviewed by the ADNS or Environmental Services Director at the next monthly PI meeting for any further recommendations. | |

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| | an employee inservice with the laundry staff had been done on 7/7/11 in the morning. The title of the employee inservice was "Laundry In-Service" and the subject was "Introduction to Infection Control".<br><br>3.1-19(g) | | | |
| F0514<br>SS=D | The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.<br><br>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.<br>Based on observation, interview and record review, the facility failed to ensure clinical records were complete by failing to have a physician's order for the administration of oxygen for 1 of 5 residents reviewed for oxygen administration in a total sample of 16 (Resident #27).<br><br>Findings include:<br><br>During review of the June 2011 and the July 2011 physician's orders for Resident #27 on 7/5/11 at 1:35 p.m., no order for the administration of oxygen could be | F0514 | a. The MD for resident #27 was notified immediately and oxygen order was obtained for 2 L per nasal cannula on 7/5/11 by Unit Manager. No adverse effects were noted. b. An immediate audit was done on 7/7/11 by the Unit Managers on the residents wearing oxygen for an active order. Fourteen out of fifteen residents wearing oxygen were noted to have orders for the use of oxygen. No other resident was affected. c. The licensed nurses will be reeducated by ADON by 7/29/11 on transcribing admission and readmission orders by having another nurse verify /validate orders to ensure that doctor's | 07/29/2011 |

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| | found.<br><br>During observation of Resident #27 on 7/6/11 at 12:30 p.m., the resident was observed wearing oxygen per nasal cannula.<br><br>Nursing notes for Resident #27 indicated the resident had oxygen flowing at 2 liters per nasal cannula on the following dates and times: 6/3/11 at 2:30 p.m., 6/5/11 at 11:20 (neither a.m. nor p.m. was indicated), 6/7/11 at 6:00 a.m., 6/8/11 at 3:00 a.m., 6/12/11 at 3:00 a.m., 6/13/11 at 10:00 p.m., 6/14/11 at 4:00 a.m., 6/15/11 at 4:00 a.m., 6/16/11 at 3:00 a.m., 6/26/11 at 2:00 p.m., 6/27/11 at 8:00 p.m., 6/28/11 at 2:00 a.m., 6/29/11 at 6:00 a.m., 6/30/11 at 6:00 a.m., 7/1/11 at 4:00 a.m., and 7/2/11 at 3:00 a.m.<br><br>During interview with the Regional Consultant on 7/8/11 at 9:45 a.m., she indicated Resident #27 came back from the hospital on oxygen, but there was no physician's order for it.<br><br>Review of the oxygen administration policy on 7/8/11 at 10:00 a.m. provided by the Regional Consultant on 7/8/11 at 9:50 a.m. indicated the first step in the procedure is to obtain appropriate physician order. | | orders are being followed as per plan of care. The Unit Managers, Supervisor, or other Designee will review new admissions or readmissions orders in the clinical meeting. d. The admission/readmission charts will be reviewed daily by the Unit manager, ADNS, DNS or other Designee for oxygen orders to assure transcription/validation accuracy. A weekly audit done by the Unit Managers for 8 weeks to monitor for compliance of accuracy of oxygen delivery with orders for all residents on unit, then monthly for 4 months. The audits will be reviewed in the next monthly Performance Improvement Committee by the Director of Nursing or Administrator for any further recommendations. | |

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| F9999 | 3.1-50(a)(1)<br><br>STATE FINDING:<br><br>3.1-19 Environment and physical standards<br>(r) Hot water temperature for all bathing and hand washing facilities shall be controlled by automatic control valves. Water temperature at point of use must be maintained between one hundred (100) degrees Fahrenheit and one hundred twenty (120) degrees Fahrenheit.<br><br>This state rule was not met as evidenced by:<br><br>Based on observation, interview and record review, the facility failed to ensure water used for bathing and handwashing was maintained at temperatures between 100 - 120 degrees Fahrenheit (F) for 11 of 11 resident rooms, 2 of 2 shower rooms and an activity room. (resident rooms #1, #16, #18, #19, #23, #24, #25, #26, #35, #39, #46)<br><br>Findings include:<br><br>During environmental tours on 7/7/11 at 3:00 p.m. and 7/8/11 at 9:00 a.m. with the Maintenance Supervisor, the Housekeeping Supervisor and the | F9999 | A. The residents had the potential to be affected by not having water temperatures between 100-120 degree F for hand washing and bathing as per state rule. On 7/7/2011 at 3pm plumbers were in the facility checking for the leak under the concrete floor. All day showers had been completed and evening showers had been placed on hold related to work on the water lines. Residents scheduled for shower were given choices of a bed bath with heated water, reschedule shower after repair completed or reschedule for the following day. Plumbers were unable to locate leak until 07/08/2011. Staff and residents were notified of water temperatures being less than 100 degrees F. After repairs were completed showers were resumed. No adverse effects were noted.<br>B. Ecolab were called to discuss the temperature needed to work with the chemicals used with laundry and dietary. The temperature levels were sufficient to continue the current schedule. The laundry that could be held to keep water temperatures up for the resident's care was held. Dietary uses a device that boosts the hot water temperature used when cleaning the dishes without any adverse effects. When | 07/29/2011 |

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| | Administrator the following water temperatures were observed:<br>Room #1 water temperature = 93.6 F (7/7/11)<br>Room #16 water temperature = 92.8 F (7/7/11)<br>Room #18 water temperature = 93.2 F (7/7/11)<br>Room #19 water temperature = 94.5 F (7/7/11)<br>Room #23 water temperature = 94.8 F (7/8/11)<br>Room #24 water temperature = 87.4 F (7/7/11)<br>Room #25 water temperature = 91.5 F (7/7/11)<br>Room #26 water temperature = 90.0 F (7/8/11)<br>Room #35 water temperature = 85.7 F (7/7/11)<br>Room #39 water temperature = 93.0 F (7/7/11)<br>Room #46 water temperature = 94.5 F (7/7/11)<br>East shower room water temperature = 92.3 (7/8/11)<br>West shower room water temperature = 94.1 (7/7/11)<br>Activity room water temperature = 95.5 (7/7/11)<br><br>A review of hot water temperature logs provided by the Administrator on 7/8/11 at 9:45 a.m. indicated water temperatures | | repairs completed showers was continued as scheduled.<br>C. The water leak causing the low temperatures in the resident's rooms was repaired as soon as possible by the contracted services on 07/08/2011.<br>D. The approval for the new water pipes to be replaced above the ground in the ceiling was approved and in the process of being planned for the project to be completed as soon as possible to prevent future issues with the hot water temperature fluctuations. The Maintenance Director/designee monitored the temperatures of the hot water hourly times 24 hours, then q shift for one week after repair and then as per policy schedule to ensure water temp are sustained within specified guidelines to prevent interruptions to the resident's showers and or bathing schedules. | |

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| | in the facility had been within the 100 - 120 degree Fahrenheit range each week during January, February, March, April, May and June, 2011.<br><br>During an interview with the Maintenance Supervisor on 7/7/11 at 3:00 p.m. he indicated plumbers were currently working to find a leak under the building which was causing the water temperatures to be cooler.<br><br>During an interview with the Maintenance Supervisor on 7/8/11 at 9:00 a.m. he indicated plumbers were still searching for the leak.<br><br>3.1-19(r) | | | |